

pre-employment assessment centre that costs increasing amounts of money each year; at a time when money is so short for hospitals and primary care, it seems inopportune to be pressing for yet further subdivision of medical manpower and spending large sums of money, which in my district are now well over £100 000 a year, on an activity that has never been proved to be greatly beneficial.

The tendency for doctors to superspecialise creates considerable problems of manpower planning and, in certain specialties, of adequate job satisfaction. I think this is probably present in community medicine. This specialty, often criticised by other colleagues who wonder exactly what they do, could, I think, emulate their predecessors, the old medical officers of health, and take on a much greater clinical role, including, as I think Professor Lee suggests, an active clinical interest in the organisation of occupational medicine. This would provide the satisfactory manpower source for Professor Lee's group, as there may be a reasonable number of senior registrars entering community medicine, some of whom would probably prefer the more clinically orientated specialty of occupational medicine. This then would place the occupational medical service firmly in the court of the new district health authorities, and perhaps in the hospital service we could rely on individual hospitals to care for their own staff through the established clinical departments, which is certainly cheaper and more efficient.

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Teenagers and contraception

SIR,—Since the publication of the General Medical Council's "blue pamphlet,"¹ it seems both ethically and legally proper for a doctor to prescribe the oral contraceptive pill to a girl under the age of 16 without informing her parents or legal guardians.

In its revised advice on standards of professional conduct and medical ethics, the General Medical Council goes so far as to emphasise that the doctor must maintain professional secrecy if so requested by a minor seeking contraceptive advice. Of course this does not and should not influence a doctor's clinical judgment whether or not a prescription should be given. There is no precedent in civil case law to contradict this advice. In the case brought by Mrs Gillick last month, Mr Justice Woolf passed a much publicised judgment, which, together with public statements by the Medical Defence Union, give reasonable grounds for assuming that a doctor who prescribes the oral contraceptive pill to a minor has little to fear from threats of civil litigation by parents for assault due to invalid consent, even if, for example, the doctor had conducted a full pelvic examination, or if the girl were to die or suffer permanent harm as a direct result of a pulmonary embolus caused by the contraceptive pill.

Both the General Medical Council and the civil case law have chosen not to specify a lower age limit. The criminal law is, however, very clear on the ages of consent. It is true that in the normal course of events doctors acting in good faith are quite safe from the criminal law, which requires the prosecution to show malicious intent beyond reasonable doubt. Nevertheless, doctors should be made aware that the likelihood of criminal prosecution against a lad over the age of 13 rises very sharply in cases of unlawful sexual intercourse with a girl under the age of 13. In addition, the doctor must exercise extreme caution not to be seen to encourage "under age sex," or

allow any act or statement to be so interpreted. Two statutes of the criminal law are relevant. Firstly, the Sexual Offences Act 1956 views sexual intercourse with a "consenting" 12 year old (section 5) in a different light to sexual intercourse with a "consenting" 13, 14, or 15 year old girl (section 6). The magnitude of this difference of legal perception is that between life imprisonment and a maximum of two years' imprisonment. Even an attempt at sexual intercourse with a girl of 12 can lead to a seven year sentence, whereas an attempt with a 13 year old carries a maximum of two years' punishment. Furthermore, there are several circumstances which could lead to acquittal under section 6, but which are not available as a defence under section 5. Secondly, the Indecency with Children Act 1960 proscribes the incitement of a child under the age of 14 to an act of gross indecency with a third person. Under this Act an offender can be convicted summarily by magistrates and without the consent of the Director of Public Prosecutions (section 48 of the Criminal Justice Act 1972). As no precedent has been set, this means that this Act could involve a medical practitioner in an unpleasant legal experience, even if a higher court were later to clarify the issue.

Scanning through the popular medical press it would seem that many doctors, especially general practitioners in deprived areas, have good reason to feel increasingly vulnerable to civil litigation, spurious allegations of indecent assault, and even threats of grievous bodily harm from irate parents. I think that many colleagues hoped that the General Medical Council would offer unambiguous guidance not only on the ethical matter of confidentiality but also on the legal matter of consent, with which confidentiality is indivisibly bound in the provision of contraception to girls under 16. I believe at the very least a specified lower age limit would give the profession greater confidence in dealing with some very difficult and sensitive cases. Sadly, it looks as though we will have to muddle along until a doctor with sufficient courage or ignorance, or both, provides us with a test case.

I for one cannot possibly conceive of a set of circumstances in which I would prescribe the pill to a girl under the age of 14, and it is unlikely that I will do so for a girl under the age of 16 without the knowledge of at least one of her parents.

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¹ General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1983.

SIR,—We are writing to express the concern of the Christian Medical Fellowship about the new guidelines on confidentiality approved by the General Medical Council.¹

The need to restate the importance of confidentiality in general is well met by the new guidelines. We would, however, strongly recommend and press for a change in emphasis in the paragraph relating to the treatment of minors requesting pregnancy or contraceptive advice. The relevant paragraph (4, under "Professional confidence") reads as follows: "Where a minor requests treatment concerning a pregnancy or contraceptive advice, the doctor should particularly have in mind the need to avoid impairing parental responsibility or family stability. The doctor should assess the patient's degree of parental dependence and seek to persuade the patient to involve the parents (or guardian or other person in loco parentis) from the earliest stage of consultation. If the patient refuses to allow

the parent to be told, the doctor must observe the rule of professional secrecy in his management of the case." The "rule" referred to is defined in paragraph 1—namely: "It is a doctor's duty to his patient (except in the cases mentioned below) strictly to observe the rule of professional secrecy by refraining from disclosing voluntarily to any third party information which he has learned directly or indirectly in his professional relationship with the patient. The death of the patient does not absolve the doctor from the obligation to maintain secrecy."

In advising and treating all children under the age of 16 years the doctor in the end has to choose between (a) honouring the confidentiality of the child, and (b) responsibility for the child in the context of family and parental duty. The GMC ruling, as stated, unequivocally comes down on the side of the child's wishes. Should the same bias be maintained in other matters, as, for example, when considering drug abuse, paedophilia, or other forms of child abuse, doctors will collude with such young people in damaging their emotional and physical health when instead our medical duty should be to promote it.

We would urge that the order of priority be changed, putting a doctor's responsibility to care for the child first (as seen by the doctor in relation to the family, where known) and the confidentiality of the child second. We suggest that the last two lines of the above clause 4 be rephrased as follows: "If the patient refuses to allow the parent to be told, the rule of professional secrecy shall normally be of secondary consideration to that of responsible care in relation to the child's legal parents or guardians if and when available for consultation."

We trust that the GMC will modify the above directive. As it stands it will cause unwarranted stress of conscience to many practitioners besides the members of the Christian Medical Fellowship.

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¹ General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1983.

SIR,—The implication of the General Medical Council's ruling contained in the new edition of *Fitness to Practise*¹ in respect of minors, confidentiality, and contraceptive practices is a direct attack on the integrity of the family. In the past family planning propaganda has operated on the slogan "responsible parenthood" but it is now rightly understood that the responsible parent has become a barrier to a contraceptive way of life for children. Parental responsibility must be encouraged, otherwise the love of the parent will be replaced by the anonymous all powerful state. Recent history and present events in oppressive regimes should be a salutary lesson.

Respect for parenthood leads to respect for childhood, with its need for love and protection. At a time when general practitioners are becoming known as family doctors how incongruous it will be if the same family doctors become instrumental in the break up of family life. The family should be respected for what it is, an essential unit in which the child can develop its human qualities and

whose function can never be legitimately usurped by any public or medical body.

Since it has been known that I have opposed the GMC's ruling on confidentiality in respect of minors, I have received over 70 expressions of support from doctors, parents, and others who view the GMC's guidelines on contraception and childhood confidentiality with great distaste.

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¹ General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1983: 20.

SIR,—During recent months a great deal of publicity has been given to one aspect of the problems of the age of consent to medical treatment. In their concentration on the problems of under age sex the media and doctors have ignored two vitally important consequences of the recent pronouncements allowing doctors to prescribe the pill to under age patients.

The first of these considerations is the unusual and indeed unprecedented way in which this change of practice has been initiated. The last legislation in this matter was in the Family Law Reform Act of 1969, which stated that minors of the age of 16 or over were entitled to give consent to medical or surgical treatment. No alteration was made in the position of the under 16 year old patient, where parental consent was previously necessary save in the circumstances of immediately necessary procedures. This Act remains on the statute book and as yet there has been no move to amend it. The first sanction to alter this long established professional practice came in a statement from the Department of Health and Social Security suggesting that doctors were allowed to prescribe the pill to under 16 year olds without parental consent where the doctor deemed this desirable. In other words, our practice as previously sanctioned by law was to be changed not by amending legislation but by bureaucratic edict. Additionally, the General Medical Council in its latest booklet has now advised doctors that they may take into account the degree of parental dependence of a patient under 16 in assessing the right to give consent to the contraceptive pill.¹ This question of parental dependence raises an entirely new concept that has not previously been expressed either as a professional ethical consideration or in legal practice. For example, would a plea that a girl of 14 was independent of her parents be accepted as a defence in the case of a boy of 17 accused of unlawful sexual intercourse? It would seem that such advice involves not merely professional ethics but also an alteration in established principles of law. If these two pronouncements are correct it does mean that at 14 a girl is legally entitled to be supplied with the pill but not legally able to consent to the act of sexual intercourse for which she has obtained the pill—which makes nonsense of the law. We are set on a very dangerous course if the law can now be altered by either bureaucratic edict or professional advice.

The second far reaching consideration is that this proposal can in no way be limited to the pill but must inevitably be extended to cover any form of treatment or examination for anyone under 16 without the consent of parent or guardian. As there has been no specific amendment to the law indicating, say, that girls of 13 to 16 may be prescribed the pill, then there must be no barrier to children of any age being considered as able to consent to all forms of medical or surgical treatment. I cannot believe it is the intention of our legislators to allow doctors to perform major or minor operations, to carry out internal examinations and various investigations, and in general to administer any treatment to children of all ages without reference to parents under normal circumstances. That, however, is the logical conclusion from every pronouncement about the rights of under 16 year olds to consent to this particular form of treatment.

English law and its procedures have been established over the centuries as the bulwark of our constitution and our civilisation. I suspect that the protagonists of these new liberties are not willing to submit them to the normal constitutional procedures and scrutinies, but to ignore these long established safeguards is always fraught with danger. I would suggest that the present obsession with one particular problem has led to the complete neglect of the possible consequences of making administrative decisions without due regard to the legal implications. Only a complete judicial or parliamentary review of the legal status of the under 16 year olds can resolve the present unsatisfactory situation.

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¹ General Medical Council. *Professional conduct and discipline: fitness to practise*. London: GMC, 1983.

New devices: drug convertarule

SIR,—On checking the table that aligns mass and molar units in the article by Dr M J Brodie and others (9 April, p 1195) we find an error in the data for quinidine. The authors quote a therapeutic range for this drug of 1.5-5.5 mg/l and express this as 6.2-16.9 μ mol/l. Taking the molecular weight of anhydrous quinidine free base as 324.4, the molar range should be 4.6-16.9 μ mol/l.¹ On cross checking further data we also discover that the conversion factor given in reference 1 for procainamide is incorrect, as it is calculated for the hydrochloride and not for the free base. We also find it difficult to understand how a molar unit range can be quoted for gentamicin, which is not a single chemical species but a mixture.

Our aim in pointing out these errors is not to denigrate the efforts of these workers but to draw attention to the inherent dangers in using the molar system for drugs. If Dr Brodie and his colleagues, who presumably had ample time to compile their conversion table, can make such mistakes, the chances are that the hard pressed clinical chemist (or physician for that matter) will make many more. In our view the SI mass unit system (μ g/l, mg/l, g/l) should be adopted universally for drug measurements. The molar SI system holds no attraction for physicians and is anathema to the analyst. We hope this letter will drive another nail into its coffin.

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¹ Taylor WJ, Finn AL, eds. *Individualising drug therapy*. New York: Gross, Townsend, Frank, 1981.

*.*We sent a copy of this letter to the authors, one of whom replies below.

SIR,—Although the molar range for quinidine in the table is indeed in error, this is because of a mistake in the metric range, which should read 2.0-5.5 mg/l, as can be seen in the figure. The molar range quoted (6.2-16.9 μ mol/l)

thus agrees with Dr Widdop and Dr Ramsey's own calculation. The conversion factor for procainamide given in reference 1 is irrelevant¹ as we took the value quoted in reference 2 for our calculations² (molecular weight 235.5; conversion factor 4.25), which is correct. The gentamicin "conversion" was included as therapeutic drug monitoring of gentamicin is mandatory and it would have been inappropriate to omit this drug from such a clinical aid. In view of the mass of the basic structure a mean value for the molecular weight of gentamicin was used and this clearly will not result in clinically relevant error.

Standardisation of the units by which drugs are measured must rate a high priority. Of the participants in the Health Control External Quality Assurance Scheme, 36% laboratories report routine drug assay results solely in SI molar units and 58% solely in mass units.³ In the same issue of the *British Journal of Clinical Pharmacology* the options were reviewed in depth and both the reviewers and the editor came out in favour of molar units.^{4,5} I must admit to a preference for retaining mass units as prescribing in molar units will clearly never be a practical proposition. Until standardisation is finally achieved, however the drug convertarule would provide a practical guide for the clinician and protection for the patient.

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¹ Deom A, Aeschlmann JM, Aellig A. Conversion scales for commonly requested serum concentrations of drugs and other substances of therapeutic and toxicological importance and of hormones. *Lancet* 1980;i:1241-4.

² Richens A, Marks V, eds. *Therapeutic drug monitoring*. Edinburgh: Churchill Livingstone, 1981.

³ Williams J. Standardisation of units of drug concentration measurement. *Br J Clin Pharmacol* 1983;16:115.

⁴ Stewart MJ, Watson ID. Standard units for expressing drug concentrations in biological fluids. *Br J Clin Pharmacol* 1983;16:3-7.

⁵ Richens A. Standard units for expressing drug concentrations in biological fluids. *Br J Clin Pharmacol* 1983;16:1.

Panic disorder

SIR,—Dr Christopher Bass and Dr W N Gardner (4 June, p 1818) may be right in their objection to equating the term panic disorder with cardiac neurosis and effort syndrome; a perennial problem with psychiatric terminology is loose definition of terms, and the *Diagnostic and Statistical Manual of Mental Disorders* has done a service in offering a concise definition of one form of anxiety disorder. More knowledge of the aetiological, prognostic, and therapeutic correlations of this disorder will result only from a strict adherence to that definition, and research findings based on inexact definitions will only perpetuate confusion.

Professor Isaac Marks (23 July, p 290) appears to have overlooked the whole purpose of my original article (30 April, p 1376), which was to draw attention to the distinction between true panic disorder and agoraphobia. I agree with Dr D S Samarasinghe's view (4 June, p 1819), albeit sceptical, that only careful testing of hypotheses will establish facts.

Dr P A McCue (28 May, p 1750) supports the view that panic disorder is a result of hyperventilation; doubtless overbreathing may produce some unpleasant sensations and even "funny turns," but there is at present no evidence that overbreathing is a precursor of